Supreme Court, U.S.
FILED
AUG 9 / 2005
OFFICE OF THE CLERK

NO. 04-1144

IN THE

Supreme Court of the United States

KELLY A. AYOTTE,
ATTORNEY GENERAL OF NEW HAMPSHIRE,

Petitioner,

v.

PLANNED PARENTHOOD OF
NORTHERN NEW ENGLAND *ET AL.*,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF OF *AMICAE CURIAE* MAUREEN L. CURLEY AND OTHER WOMEN ATTESTING TO THE IMPORTANCE OF PARENTAL NOTIFICATION FOR THE ABORTION DECISION OF MINORS IN SUPPORT OF PETITIONER

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Dated: August 8, 2005

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INTEREST OF *AMICAE CURIAE*[1]

Amicae, who are listed and described in the Appendix, are women who attest to the importance of parental notification for minors contemplating abortion. They include (i) women who were pregnant before the age of eighteen and experienced the need for a parent's guidance, (ii) women medical professionals who have studied and treated the adverse psychological effects of abortion on women, and (iii) mothers who were unable to provide guidance and support to their pregnant daughters when they were contemplating abortion because they were not aware of their daughters' crisis pregnancies. All of these women believe that minors contemplating abortion, regardless of their ultimate decisions, benefit from parental notification. *Amicae* believe that parental notification protects the health and psychological well-being of pregnant minors by giving parents an opportunity to provide their pregnant daughters with guidance and support at a critical time in their lives.

SUMMARY OF ARGUMENT

The choices facing a pregnant minor are stark and potentially life-altering. On the one hand, the teen can choose to give birth; on the other, she can choose to abort. Both decisions are momentous and fraught with physical, emotional, and psychological consequences that can last well into adulthood. Minor children who become teen mothers are more likely to drop out of high school and live in poverty, more

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[1] Counsel for both parties have consented to the filing of this *amicus* brief. Their written consents are on file with the Clerk of the Court. No counsel for a party authored this brief in whole or in part. The Pro-Life Legal Defense Fund, Inc., contributed the printing costs associated with the preparation and submission of this brief. Unless otherwise noted, all statements made by *amicae* are on file with counsel for *amicae curiae*.

likely to experience premature labor, and more likely to give birth to babies that suffer health and developmental problems, such as low birth weights. Those who abort their pregnancies also face serious health consequences. In particular, they are more likely to experience mental and emotional problems, more likely to commit suicide, more likely to develop substance abuse problems, and more likely to face future risks of pregnancy complication than women who give birth.

Recognizing these health consequences surrounding a teenager's abortion decision, New Hampshire exercised its power to protect the health of its minors by seeking to involve their parents in abortion-related decisions when it enacted the Parental Notification Prior to Abortion Act ("the Act") in 2003. In so doing, New Hampshire is treading lightly; rather than requiring parental consent as many other States have done, New Hampshire merely requires parental notice. This notice helps to support the minor's decision-making process with parental guidance and information. Where parental notification is impossible or undesirable, New Hampshire provides for around-the-clock access to its courts for judicial bypass, with courts statutorily required to push other business aside and rule promptly in the minor's best interests (including potentially appointing a guardian *ad litem* to protect the child's best interests). By these measures, New Hampshire has established a policy that its minors should not undergo abortion without the involvement of an adult (either a parent, the court, or a court-appointed guardian) who will protect her best interests before she undergoes what is usually a surgical procedure. For emergencies, the Act contains an express exemption for abortions needed to save the life of a patient. Furthermore, it is subject to New Hampshire's statutory justification defenses, which preclude criminal and civil liability for any physician urgently acting to prevent serious harm to the pregnant minor, including harm to her health.

The First Circuit invalidated New Hampshire's efforts to protect the health of its pregnant minors, ostensibly out of concern for the health of those same pregnant minors. In particular, the First Circuit found the Act unconstitutional because it lacks an express exception permitting abortions for emergencies that threaten a patient's health, but not her life.

The absence of an express health exception does not render the Act unconstitutional. Rather, the Act does not impose an undue burden on the right to abortion because the Act plainly provides for emergency situations *already* (by providing around-the-clock court access), and because it is subject to New Hampshire's statutory justification defense if a situation is so urgent that resorting to the courts would endanger the minor's health. In any case, there is absolutely no evidence to suggest that there ever could be a real-world health emergency that is at once so severe as to require an immediate abortion without using the emergency judicial bypass procedure, and yet is not so severe as to endanger the patient's life or qualify for the justification defense. Moreover, New Hampshire's judgment that *some* adult should be involved before a doctor performs surgery on a minor for non-life-threatening conditions is eminently reasonable, and is well within the state's power to protect the health of its citizens.

ARGUMENT

I. BOTH TEEN PREGNANCY AND ABORTION CARRY SIGNIFICANT HEALTH RISKS.

A. Teen Pregnancies Carry Health And Other Risks For Both Pregnant Minors And Their Babies.

While pregnancy avoids many of the physical and psychological health problems associated with abortion (*see infra*), teen pregnancies are associated with significant consequences for both mother and baby. According to the Centers for Disease Control: "When teens give birth, their future prospects decline. Teen mothers are less likely to complete high school, more likely to be single parents, and more likely to live in poverty than other teens." Centers for Disease Control and Prevention, *Unintended and Teen Pregnancy Prevention: Teen Pregnancy, at* http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/Teen.htm (last modified April 12, 2005).

Moreover, "[t]here are health risks to the baby and children born to teenage mothers are more likely to suffer health, social, and emotional problems. There is an increased risk for complications such as premature labor during teen pregnancy and socioeconomic consequences as well." WomensHealthChannel, *Teen Pregnancy, at* http://www.womenshealthchannel.com/teenpregnancy/index.shtm (last visited July 27, 2005).

B. Abortion Carries Significant Physical And Psychological Health Risks, Especially For Minors.

This Court has long recognized that abortion carries significant health risks. *See, e.g., H.L. v. Matheson*, 450 U.S. 398, 411 n.20 (1981) ("Abortion is associated with an increased risk of complication in subsequent pregnancies."); *id.* (noting "the emotional and psychological effects of the pregnancy and abortion experience" and citing their potential "considerable harms" to minor women); *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992) (citing the "devastating psychological consequences" that can flow from an uninformed abortion decision).

Recent studies provide further evidence that abortion can have both short-term and long-term negative psychological consequences for women, especially adolescent women.[2] In particular:

1. Abortion increases the risk of mental health problems.

Recent epidemiological studies have found that women who have abortions are more likely to require treatment for mental health disorders, such as depressive psycho-

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[2] Of particular note are the increasing number of epidemiological studies that show an association between abortion and adverse effects, such as suicide, psychiatric admission, and self-harm. These studies are particularly significant because they use large sample sizes, collect data from objective outcome measures (e.g., suicide) rather than subjective outcome measures (e.g., patient self-reports), and use medical records that link a history of abortion with other health issues. In contrast, many earlier studies of the mental health status of women after abortion rely on small sample sizes and experience high drop-out rates. Ney & Wickett, *Mental Health and Abortion: Review and Analysis*, 14 Psychiatric J. Univ. of Ottawa 506 (1989).

sis, neurotic depression, bipolar disorder, adjustment reactions, and schizophrenic disorders, than women who give birth. One recent study of the medical records of 56,741 low-income patients in California found that women who had abortions were 2.6 times more likely than women who gave birth to be hospitalized for psychiatric treatment in the first ninety days following abortion or delivery. Reardon *et al., Psychiatric Admissions of Low-Income Women following Abortion and Childbirth*, 168 Can. Med. Ass'n J. 1253 (2003); *see also* David, Rasmussen, and Holdt, *Post-abortion and Postpartum Psychotic Reactions*, 13 Fam. Planning Perspectives 32 (1981) (study of 98,612 women in Denmark found that the psychiatric admission rate was 18.4 per 10,000 women after abortion versus 12 per 10,000 women after childbirth). Women who had abortions were also more likely to be hospitalized during the four-year period examined. Reardon *et al., supra.*

Another recent epidemiological study of the medical records of 173,000 low-income patients in California found that women who had abortions were sixty-three percent more likely to receive outpatient psychiatric treatment within ninety days of an abortion than women who gave birth. Coleman *et al., State-funded Abortions vs. Deliveries: A Comparison of Outpatient Mental Health Claims over Five Years*, 72 Am. J. of Orthopsychiatry, 141 (2002). During the four-year period examined, women who had abortions were also more likely to be hospitalized.

Additionally, women who abort a first pregnancy are at greater risk of long-term clinical depression, compared with women who carry a first pregnancy to term. Cougle *et al., Depression Associated with Abortion and Childbirth: A Long-term Analysis of the NLSY Cohort*, 9 Med. Sci. Monitor 105 (2003) (study of 1,884 women who participated in National Longitudinal Survey of Youth between 1980 and 1992). Younger women are especially at risk of adverse psy-

chological consequences after abortion. Zolese & Blacker, *The Psychological Complications of Therapeutic Abortion*, 160 Brit. J. of Psychiatry 742 (1992); Franz & Reardon, *Differential Impact of Abortion on Adolescents and Adults*, 27 Adolescence 161 (1992).

2. Abortion increases the risk of emotional problems.

Women who have abortions are also more likely to experience emotional distress than women who give birth. One study found that women who aborted their unintended first pregnancies and had no prior history of anxiety were thirty percent more likely to subsequently report all the symptoms of generalized anxiety disorder (GAD) than those women who had carried their unintended first pregnancies to term. Cougle *et al., Generalized Anxiety Following Unintended Pregnancies Resolved Through Childbirth and Abortion: A Cohort Study of the 1995 National Survey of Family Growth*, 19 J. of Anxiety Disorders137 (2005) (study analyzing nationally representative sample of 10,847 women aged 15-34). Teenagers in particular were more likely than adults to experience anxiety. *Id.* Additionally, research has shown that "teenagers who do not tell their parents about their abortion have an increased incidence of emotional problems and feelings of guilt." Rosenfeld, *Emotional Responses to Therapeutic Abortion*, 45 Am. Fam. Physician 137, 138 (1992).

Another study of 854 Swedish women following their abortions found that more than fifty percent of the women reported experiencing emotional distress. Söderberg & Sjöberg, *Emotional Distress following Induced Abortion: A Study of its Incidence and Determinants among Abortees in Malmö, Sweden*, 79 Eur. J. of Obstetrics & Gynecology 173 (1998). This distress was classified as severe, requiring pro-

fessional psychiatric treatment, among sixteen percent of the women. *Id.* Likewise, a study of women up to two years after their abortions found that twenty percent reported depressed moods and negative emotions because of their abortions. Major *et al.*, *Psychological Responses of Women After First-Trimester Abortion*, 57 Archives of Gen. Psychiatry 777 (2000). Their negative emotions regarding the abortion increased over time while their satisfaction with their decision decreased over time. *Id.*

Some women also experience post-traumatic stress disorder (PTSD) after abortion. *Id.* (study of 442 women found that 1% reported PTSD within two years of abortion); Catherine Barnard, The Long-Term Psychological Effects of Abortion, Portsmouth N.H.: Institute of Pregnancy Loss (1990) (study found that 18.8% of women who had abortions reported experiencing all of the symptoms of PTSD three to five years after their abortions, and almost 50% reported experiencing multiple symptoms of PTSD).

3. Abortion increases the likelihood of future substance abuse.

Women who have abortions are also at greater risk of abusing drugs and alcohol than women who give birth. A recent study found that women who have an abortion are five times more likely to report subsequent substance abuse than women who give birth. Reardon & Ney, *Abortion and Subsequent Substance Abuse*, 26 Am. J. Drug & Alcohol Abuse 61 (2000) (study of a random sample of 700 women, ages 24 to 44). Additionally, women with a prior history of abortion are twice as likely to use alcohol, five times more likely to use illicit drugs, and ten times more likely to use marijuana during the first pregnancy they carry to term, compared with other women delivering their first pregnancies. Coleman *et al.*, *History of Induced Abortion in Relation to Substance*

Use During Pregnancies Carried to Term, 187 Am. J. of Obstetrics & Gynecology 1673 (2002) (study of nationally representative sample of 2,613 women who had recently given birth).[3]

Research has also identified an association between abortion and drug and alcohol abuse among adolescent women. Amaro *et al.*, *Drug Use Among Adolescent Mothers: Profile of Risk*, 84 Pediatrics 144 (1989).

4. Abortion increases the risk of suicide.

Finally, studies also suggest that women who have abortions, particularly minors who have abortions, are more likely to commit and attempt suicide than women who give birth and non-pregnant women.

Recent epidemiological studies linking the medical and death records of large samples of women have shown that suicide rates are three to six times higher for women who have abortions than for women who give birth. Gissler *et al.*, *Suicides after Pregnancy in Finland, 1987-94: Register Linkage Study*. 313 Brit. Med. J. 1431 (1996) (national study of women in Finland found that women who had abortions were 6.5 times more likely to commit suicide than women who had given birth); Reardon *et al.*, *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low-Income Women*, 95 So. Med. J. 834 (2002) (study of

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[3] Further studies also show a link between abortion and substance abuse. *E.g.*, Wilsnack *et al.*, *Women's Drinking and Drinking Problems: Patterns from a 1981 National Survey*, 74 Am. J. of Pub. Health 1231 (1984); Frank *et al.*, *Cocaine Use during Pregnancy, Prevalence and Correlates*, 82 Pediatrics 888 (1988); Klassen & Wilsnack, *Sexual Experience and Drinking among Women in a U.S. National Survey*, 15 Arch. Sexual Behavior 363 (1986).

173,279 women who had state-funded abortions or deliveries found that women who had abortions were 3.1 times more likely to die from suicide compared to women who gave birth). Morgan *et al.*, *Suicides After Pregnancy: Mental Health May Deteriorate as a Direct Effect of Induced Abortion*, 314 Brit. Med. J. 902 (1997) (study of women in Wales found suicide much more likely for women who had abortions as compared with women admitted for normal delivery).[4]

The risk of suicide following an abortion is particularly high among adolescent women. Compared to adult women, adolescents are more than twice as likely to attempt suicide following an abortion. Campbell *et al.*, *Abortion in Adolescence*, 23 Adolescence 813 (1988). Adolescents who abort are also more likely to commit suicide than adolescent women in general. Gissler *et al.*, *Suicides after Pregnancy in Finland: 1987-94: Register Linkage Study*, 313 Brit. Med. J. 1431 (1996). A survey study of Minnesota high school students also found that adolescent women were ten times more likely to attempt suicide in the six months after an abortion than adolescents who did not have abortions. Garfinkel *et al.*, *Stress, Depression and Suicide: A Study of Adolescents in Minnesota*, Responding to High Risk Youth 43-55

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[4] Clinical case studies and self-reports of women who have had abortions also indicate a correlation between abortion and subsequent suicides and attempted suicides. *See generally* Angelo, *Psychiatric Sequelae of Abortion: The Many Faces of Post-Abortion Grief*, 59 Linacre Q. 69 (1992). *See also* Grimes, *Second-Trimester Abortions in the United States*, 16 Fam. Planning Perspectives 260 (1984); Sim & Neisser, *Post-Abortive Psychoses: A Report from Two Centers*, in The Psychological Aspects of Abortion (David Mall & Walter F. Watts eds., 1979); Anne Speckhard, The Psycho-Social Stress Following Abortion (Kansas City, Mo.: Sheed & Ward, 1987).

(Minnesota Extension Service, University of Minnesota) (1986).[5]

II. THE STATE MAY CONSTITUTIONALLY ACT TO PROTECT THE HEALTH AND PSYCHOLOGICAL WELL-BEING OF MINORS BY REQUIRING PARENTAL NOTIFICATION.

In light of the profound health consequences that arise from a minor's abortion decision, it is no surprise that this Court has repeatedly found that States may act to protect minors' health and welfare by requiring involvement of parents in abortion decisions.

A. States Have Constitutional Authority To Regulate Abortion To Protect Physical And Psychological Health.

This Court has long recognized that where regulations concern how best to protect the health of citizens, the States should be permitted great latitude to make their own judgments. *See, e.g., Medtronic, Inc. v. Lohr*, 518 U.S. 470, 474 (1996) (internal citations omitted) ("Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens. Because these are primarily, and historically, . . . matter[s] of local concern, the States traditionally have had great latitude under their police powers to legislate as to the protection of lives, limbs,

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[5] More detailed information about the negative psychological consequences of abortion for women is available in "The Impact of Abortion on the Public Health and Welfare", a paper by psychiatric nurse Maureen L. Curley, which collects much of the research set forth above. A copy of the Curley article was submitted with the Brief of Amici Curiae Maureen L. Curley *et al.* at Appendix, *McCorvey v. Hill*, 125 S. Ct. 1387 (2005) (No. 04-967).

health, comfort, and quiet of all persons."); *see also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756 (1985).

This power includes the power to regulate abortion to protect women's physical and psychological health. *Roe v. Wade* emphasized the State's interest in protecting the pregnant woman's health. 410 U.S. 113, 162 (1973). *See also Planned Parenthood v. Casey*, 505 U.S. 833, 878 (1992) ("As with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion."). This Court has upheld various regulations motivated by such concerns, from licensing standards for abortion facilities, *see, e.g., Roe*, 410 U.S. at 163, to more general requirements tailored to inform the woman's free choice by communicating to her the risks of abortion, *see, e.g., Casey*, 505 U.S. at 881-84 (upholding an informed consent provision).

This Court has expressly acknowledged that psychological well-being is a component of the woman's health for the purposes of abortion regulation. *See, e.g., Doe v. Bolton* 410 U.S. 179, 192 (1973); *see also Casey*, 505 U.S. at 882 ("it cannot be questioned that psychological well-being is a facet of health"). In *Casey*, for example, the Court stated:

> In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.

Id.

B. States May Constitutionally Require Parental Notification Prior To A Minor's Abortion.

This Court has long recognized that the right of minors to choose abortion raises special concerns, and that States have a legitimate interest in trying to protect the health of minors by bringing parents and guardians into the decision-making process.

1. Minors require special protection.

This Court has recognized two principal concerns about minors choosing abortion without a parent's or guardian's involvement. First, minors may be ill-suited to make mature and informed choices about abortion without parental guidance. Second, minors may be uniquely vulnerable to deleterious psychological consequences of a poor decision.

The Court's recognition of the incapacity of some minors to make the abortion decision without parental guidance dates back to 1976 and *Planned Parenthood v. Danforth*:

> There can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents in making the very important decision whether or not to bear a child. That is a grave decision, and a girl of tender years, under emotional stress, may be ill-equipped to make it without mature advice and emotional support. It seems unlikely that she will obtain adequate counsel and support from the attending physi-

> cians at an abortion clinic, where abortions for pregnant minors frequently take place.

428 U.S. 52, 91 (1976) (Stewart, J., concurring).

The Court has echoed this sentiment several times over the past thirty years. *See, e.g., Bellotti v. Baird*, 443 U.S. 622, 635 (1979) ("during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them"); *Hodgson v. Minnesota*, 497 U.S. 417, 444 (1990) ("The State has a strong and legitimate interest in the welfare of its young citizens, whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely"); *id.* at 459 ("Inexperience, less education, and less intelligence make the teenager less able to evaluate the consequences of his or her conduct while at the same time he or she is much more apt to be motivated by mere emotions or peer pressure than is an adult").

Furthermore, the negative consequences of poor abortion choices—which this Court recognized as potentially "devastating" in *Casey*—fall particularly heavily on minors. *See H.L. v. Matheson*, 450 U.S. 398, 411 n.20 (1981) ("The emotional and psychological effects of the pregnancy and abortion experience are markedly more severe in girls under 18 than in adults. Because of these considerable harms to minor women, combined with their general lack of capacity to grant effective consent, regulation in the context of minor women is especially needed to protect their interests in health and psychological well-being.");[6] *see also* pp. 9-11

[6] The Court's concern about the decision-making ability of minors, of course, extends well beyond the realm of abortion. As this Court observed last Term in *Roper v. Simmons*, "[a] lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults and . . . often result in impetuous and ill-considered actions

supra (noting that minors who have abortions are more likely to attempt or commit suicide).

2. Parental notification laws are a constitutional means of protecting the health and psychological well-being of minors considering abortion.

This Court has repeatedly found that parental consent laws are a legitimate way for a State to protect the physical and psychological health of pregnant minors from the potential health issues arising from a teenager's abortion decision. As this Court explained in *Bellotti*, 444 U.S. at 640:

> As immature minors often lack the ability to make fully informed choices that take account of both immediate and long-range consequences, a State reasonably may determine that parental consultation often is desirable and in the best interest of the minor. It may further determine, as a general proposition, that such consultation is particularly desirable with respect to the abortion decision—one that for some people raises profound moral and religious concerns.

(internal citations omitted). *See also Danforth*, 428 U.S. at 102-03 (Stevens, J., concurring in part and dissenting in part) ("The State's interest in protecting a young person from harm justifies the imposition of restraints on his or her freedom even though comparable restraints on adults would be constitutionally impermissible. . . . Whatever choice a pregnant young woman makes—to marry, to abort, to bear her

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and decisions . . . . In recognition of the comparative immaturity and irresponsibility of juveniles, almost every State prohibits those under 18 years of age from voting, serving on juries, or marrying without parental consent." 125 S.Ct. 1183, 1195 (2005) (internal citations omitted).

child out of wedlock—the consequences of her decision may have a profound impact on her entire future life. A legislative determination that such a choice will be made more wisely in most cases if the advice and moral support of a parent play a part in the decisionmaking process is surely not irrational."); *Matheson*, 450 U.S. at 411 ("As applied to immature and dependent minors, the statute plainly serves the important considerations of . . . protecting adolescents. . . . The medical, emotional, and psychological consequences of an abortion are serious and can be lasting; this is particularly so when the patient is immature."); *see also Danforth*, 428 U.S. at 102 ("the holding in *Roe v. Wade* that the abortion decision is entitled to constitutional protection merely emphasizes the importance of the decision; it does not lead to the conclusion that the state legislature has no power to enact legislation for the purpose of protecting a young pregnant woman from the consequences of an incorrect decision").

In permitting parental involvement statutes, this Court has recognized that States may rely on the expectation that most parents will act in the best interests of their child. *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502, 520 ("It is both rational and fair for the State to conclude that, in most instances, the family will strive to give a lonely or even terrified minor advice that is both compassionate and mature. The statute in issue here is a rational way to further those ends."); *see also Hodgson*, 497 U.S. at 484 ("A State may seek to protect and facilitate the parent-child bond on the assumption that parents will act in their child's best interests."); *Matheson*, 450 U.S. at 424 (Stevens, J., concurring in the judgment) ("The possibility that some parents will not react with compassion and understanding . . . does not undercut the legitimacy of the State's attempt to establish a procedure that will enhance the probability that a pregnant young woman exercise as wisely as possible her right to make the abortion decision."). The State's efforts to encourage such parent-child discussions are particularly necessary

because, as this Court recognized in *Casey*, "children will often not realize that their parents have their best interests at heart." 505 U.S. at 895.

Similarly, this Court has noted that parental involvement in the abortion decision is invaluable for more than the support and guidance it provides. Parents can also supply important medical information that bears directly on the contemplated abortion — information that may not otherwise be weighed in determining what is truly best for the minor. *See Matheson*, 450 U.S. at 411:

> In addition, as applied to that class, the statute serves a significant state interest by providing an opportunity for parents to supply essential medical and other information to a physician. The medical, emotional, and psychological consequences of an abortion are serious and can be lasting; this is particularly so when the patient is immature. An adequate medical and psychological case history is important to the physician. Parents can provide medical and psychological data, refer the physician to other sources of medical history, such as family physicians, and authorize family physicians to give relevant data.

(internal note omitted); *see also amica* Eve Sanchez Silver, Appendix, *infra* at 4a. Thus, the Court has recognized the obvious proposition that minors are better cared for when parents are included in their medical decisions.

III. NEW HAMPSHIRE'S DECISION TO PROTECT THE HEALTH AND WELFARE OF ITS PREGNANT MINORS THROUGH PARENTAL NOTIFICATION SHOULD NOT BE INVALIDATED BY THE ABSENCE OF AN EXPRESS HEALTH EXEMPTION.

The First Circuit's ruling is largely premised on its theory that there might be situations in which the absence of an express health exemption would impose an undue burden for pregnant minors in need of an abortion. This view fails to appreciate key aspects of the Act and New Hampshire law, which make the Act well-suited to protect the health and welfare of New Hampshire's minors.

A. New Hampshire's Around-The-Clock Judicial Bypass System Adequately Protects The Health Of Pregnant Minors Facing Health Emergencies.

The First Circuit suggested that a pregnant minor faced with an emergency might be forced to wait fourteen days for judicial bypass. This is simply incorrect.

First, the Act only requires a wait of forty-eight hours after giving notice.

Second, the Act waives the forty-eight hour wait for life-threatening emergencies.

Third, in the event that a non-life-threatening[7] health emergency exists that requires an abortion in less than forty-

[7] Emergencies that threaten the minor's life are expressly excepted under the Act. N.H. Rev. Stat. Ann. 132:25-I (a). Therefore, the only emergencies that are even arguably unprotected by the Act are those that do *not* threaten the life of the patient.

eight hours, New Hampshire's judicial bypass process offers *immediate* relief. For such emergencies, New Hampshire has statutorily required that its courts (a) be open and available for bypass petitions around the clock, seven days a week; (b) push all other matters on the calendar aside; and (c) "reach a decision promptly and without delay so as to serve the best interests of the pregnant minor." N.H. Rev. Stat. Ann. 132:26 II (b), (c). There is simply no reason to believe that courts would not obey the statutory mandate to decide promptly in the best interests of the minor, and instead take up to two weeks to decide while a minor's health was at risk. Indeed, the only plausible reason for New Hampshire's requirement that its courts be available twenty-four hours a day and seven days a week is precisely that New Hampshire expects those courts to be able to act immediately in emergency situations. By excepting death emergencies and requiring readily available judicial bypass for health emergencies, the Act adequately protects the health of New Hampshire minors.

B. New Hampshire's Justification Statute Provides A Complete Defense To Both Criminal And Civil Liability For Physicians Performing Abortions Necessary To Avoid Substantial Harms To A Minor's Health.

The First Circuit correctly recognized that New Hampshire's "competing harms" justification defense, N.H. Rev. Stat. Ann. 627:3 I, "has the potential to protect against criminal liability under the Act." *Planned Parenthood v. Heed*, 390 F.3d 53, 61 (1st Cir. 2004). However, that court *incorrectly* asserted that the justification defense "cannot preclude civil liability." *Id.* Likewise, the First Circuit expressed concerns about the justification statute's use of an objective reasonableness standard (as opposed to a subjective

good faith analysis), and held that the justification statute would not apply to offenses defined *after* the enactment of the justification statute. Each conclusion is incorrect.

First, New Hampshire law expressly provides that any justification defense that protects against criminal liability also provides a complete defense to civil liability based on the same action. In particular, N.H. Rev. Stat. Ann. 627:1 makes clear:

> Conduct which is justifiable under this chapter constitutes a defense to any offense. *The fact that such conduct is justifiable shall constitute a complete defense to any civil action based on such conduct.*

N.H. Rev. Stat. Ann. 627:1 (emphasis supplied); *In Re Fasi*, 567 A.2d 178, 181 (N.H. 1989) ("Thus, the defense of justification is an exculpatory defense which, if proved, not only results in a finding of no criminal liability, but also relieves a defendant of any civil liability which might attach to the particular conduct in question.").

The lower court's concern about a reasonableness standard leaving doctors "uncertain" about their actions, 390 F.3d at 61, is likewise misplaced. Whether or not the Act is in effect, New Hampshire doctors are *always* subject to reasonableness standards for their actions as a result of malpractice and negligence law. *See Francoeur v. Piper*, 776 A.2d 1270, 1275 (N.H. 2001) ("The defendant in a medical negligence case is measured against the standard of reasonable professional practice."). Thus, every action a doctor takes, at any time, is judged by a reasonableness standard. Moreover, requiring doctors to act reasonably — especially if they are performing emergency surgical procedures, without the involvement of any parent or guardian on a minor whose life is *not* in danger — is hardly an "undue" burden.

The First Circuit's concern about the applicability of the justification defense to later-enacted laws, 390 F.3d at 62, is likewise baseless. After recognizing that the justification defense had the potential to protect against liability, the First Circuit explained that, because the Act was enacted subsequent to the justification statute, the justification statute does not apply. There is absolutely no reason to believe that New Hampshire's justification statute is inapplicable to offenses defined after 1973 (the effective date of the statute, which essentially codified the common law of justification or necessity). To the contrary, New Hampshire's Supreme Court has recognized the applicability of the justification defense to offenses defined *after* the enactment of the justification statute. *See State v. L'Heureux*, 846 A.2d 1193 (N.H. 2004) (recognizing justification defense for offense of driving with a blood alcohol level over .08, which was not made an offense in New Hampshire until 1993). To hold otherwise would suggest that, by going to the effort of codifying the common law of justification, New Hampshire meant to *reduce* its scope but neglected to say so. The far more logical explanation is that (as *L'Heureux* demonstrates) the justification statute is a general background principle of law that applies to all offenses unless the legislature expressly says otherwise.

C. New Hampshire's Efforts To Protect The Health Of Pregnant Minors Should Not Be Trumped Where There Is No Evidence Of Any Medical Situation That Would Require The Health Exemption.

Neither the First Circuit nor Respondents present evidence that there could ever be a health emergency requiring an immediate abortion that is not adequately addressed under New Hampshire law.

First, unlike the law at issue in *Stenberg v. Carhart*, 530 U.S. 914 (2000), the Act does not prohibit any type of abortion; rather, it merely requires notice to parents and a forty-eight hour delay after notice (or resort to judicial bypass). Thus, the class of health emergencies for which an exemption could be needed is necessarily limited to those health emergencies that are (a) so urgent that the forty-eight-hour delay would be detrimental to the minor's health, and (b) so urgent that resort to the around-the-clock emergency judicial bypass procedure would be detrimental to the minor's health.

Furthermore, the health emergency requiring immediate abortion would also need to be an emergency that is *not* severe enough as to threaten the patient's life. If it were so severe, it would come under the life exception of N.H. Rev. Stat. Ann. 132:26-I (a).

Finally, the health emergency would also have to be *not* severe enough as to qualify under the "competing harms" defense of N.H. Rev. Stat. Ann. 627:3. Alternatively, if one sees the First Circuit's fears of the reasonableness standard as valid, the emergency would have to be of so borderline a nature that a licensed abortion provider would be uncertain whether performing the emergency abortion would be viewed as reasonable.

In sum, the class of health emergencies that would require an additional exemption would include only that narrow and hypothetical situation where a pregnant minor arrived at her doctor's office with a condition such that (a) waiting forty-eight hours for notice would be detrimental to her health, and (b) taking advantage of around-the-clock judicial bypass would be detrimental to her health, but simultaneously and paradoxically (c) is *not* so severe an emergency as to endanger her life, and (d) is *not* so clearly an

emergency that the provider would know that his or her conduct would be judged reasonable in the circumstances.

There is simply no evidence that so bizarre a health emergency could possibly exist; neither the lower courts nor the Respondents appear to have identified how such an emergency could actually occur.[8] Accordingly, New Hampshire's efforts to protect its pregnant minors from real, actual health consequences should not be trumped by the First Circuit's speculation about purely hypothetical health emergencies for which there is no evidence at all.

D. The Constitution Does Not Prohibit New Hampshire's Judgment That Input Of A Parent Or Guardian Is Desirable Before Surgery Is Performed For A Non-Life-Threatening Condition.

The First Circuit and the Respondents both suggest that New Hampshire's policy of encouraging parental or judicial involvement in the abortion decision should yield where the minor faces a health emergency. But these situations demonstrate precisely why New Hampshire's law makes sense: when faced with the prospect of emergency surgery for a non-life-threatening condition, it is critical that a minor have some responsible adult — whether it be a par-

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[8] The prospect of such a hypothetical, imaginary set of circumstances being used to facially invalidate a law is precisely why *Salerno*'s "no set of circumstances" test is sensible. Indeed, the opponents of the New Hampshire law are relying on a notion that is *exactly the opposite* of *Salerno*: While *Salerno* counsels that a law should be facially valid if it can be constitutionally applied in some set of circumstances, this law's opponents wish it to be invalidated solely because it *might* be applied unconstitutionally in a completely imaginary circumstance. If this were the standard, virtually all laws could be vacated; it is not difficult to imagine that any given law might hypothetically be applied in a racially discriminatory manner, for example.

ent, the court, or a court-appointed guardian as authorized under the Act—assigned to help protect her best interests.[9]

Most abortions are surgical and require general or local anesthesia. *See, e.g.*, Centers for Disease Control and Prevention, *Abortion Surveillance – United States, 2001 (Morbidity and Mortality Weekly Report)* 4 ("For women whose type of procedure was adequately reported, 95% of abortions were known to have been performed by curettage (which includes dilatation and evacuation [D&E])...") at http://www.cdc.gov/mmwr/PDF/ss/ss5309.pdf. (last visited August 3, 2005); *see also* Planned Parenthood, *How Abortion is Performed, at* http://www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/abortion/fact-abortion-provided.xml (noting that "gentle suction curettage" is a method of surgical abortion, is the "usual" means of early abortion, and that anesthesia is generally used). While surgery and anesthesia are generally safe, they do carry some irreducible risks of complication, infection, and even death. *See, e.g.*, American Society of Anesthesiologists, *Frequently Asked Questions, at* http://www.asahq.org/patient Education/otherfaqs.htm#2 ("All operations and all anesthesia have some risks, and they are dependent upon many factors including the type of surgery and the medical condition of the patient.") (last visited August 3, 2005).

These risks also pertain to abortions. According to the Centers for Disease Control and Prevention, there were 11 abortion-related deaths in the United States in 2000. *See* Centers for Disease Control and Prevention, *Abortion Surveillance – United States, 2001 (Morbidity and Mortality Weekly Report)* at 7 ("In 2000, a total of 11 women died as a result of legal induced abortion . . . ."). Likewise, even chemical abortions—for example, RU-486—appear to carry

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[9] This is especially true where the plaintiffs and the lower courts are asserting that the provider's judgment should not even be judged by a reasonableness standard.

some risk of infection and death.[10] New Hampshire is not constitutionally prohibited from requiring that, for *non*-life-threatening emergencies, either a parent or the court should be notified to help decide whether incurring such risks for a *non*-life-threatening condition is in the minor's best interests. In this regard, the Act serves New Hampshire's legitimate interest in protecting the health of pregnant minors.

E. Reliance On Justification Statutes Would Remove A Principal Point Of Dispute Between Pro-Life And Pro-Choice Citizens And Public Servants Concerning Most Regulations Of Abortion.

Lastly, this case offers the Court a rare but important opportunity to use its decision to de-escalate the country's continuing battle over abortion. Generally speaking, legislatures that enact laws lacking health or life exceptions do not do so out of cruelty or indifference to women. Rather they do so out of concern that some abortion providers will use a subjective standard to effectively negate the law with an overly broad definition of medical emergency. Generally speaking, those who argue in favor of life and health exceptions usually do not claim that abortion can never be regulated, but rather seek an effective provision for real emergency situations, so that a woman's life or health are not harmed by the regulation.

The common law provides a logical and effective response that addresses the legitimate concerns on both sides, and on which all citizens rely to protect their life and liber-

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[10] *See, e.g.*, FDA Alert, *at* http://www.fda.gov/cder/drug/infopage/mifepristone/default.htm, (last modified July 22, 2005) ("FDA is aware of four women in the United States who died from sepsis (severe illness caused by infection of the bloodstream) after medical abortion with Mifeprex and misoprostol.").

ties every day: the justification or necessity defense. Unlike the "good faith" standard feared to be easily abused and practically unenforceable, a justification defense would carry an objective standard of reasonableness. That is the same objective standard of reasonableness on which all citizens rely when they need a fellow citizen to make a common-sense judgment to help them in an emergency, for example by running a red light to get to the hospital, or by attacking a would-be murderer or hijacker. In these situations, the law has always protected us by trusting the judgment of our fellow citizens under an objective reasonableness standard. If these standards are good enough to protect the lives, liberties, and constitutional rights of all citizens in other emergencies, there is no reason abortion laws require different treatment. The legitimate concerns of both sides would be addressed by an opinion embracing this common-sense approach—and simultaneously holding that the Constitution *requires* that such justification laws must remain applicable to restrictions on abortion.

CONCLUSION

For these reasons, New Hampshire's efforts to protect the health and welfare of its pregnant minors should be upheld as constitutional.

Respectfully submitted,

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Dated: August 8, 2005

APPENDIX

DESCRIPTIONS OF *AMICAE*

Ms. Maureen L. Curley, MS, APRN is an Advanced Practice Registered Nurse in Adult Psychiatric Nursing with licensure in Vermont and Massachusetts. As a psychiatric nurse practitioner for fifteen years, her practice includes clinical, teaching, and research specializing in women's mental health with a focus in psychological stress disorders after abortion. Currently, Ms. Curley is a PhD candidate at McGill University in Montreal, Canada where she is researching post abortion reactions among college students. She provided expert testimony in support of parental notification of abortion for minors before the Vermont State Legislature's Health and Welfare, as well as Judiciary Committees in 2001 and 2002. Her professional affiliations include membership with the American Psychiatric Nurses Association and Sigma Theta Tau National Honor Society of Nursing.

Ms. Lisa Alekna, M.Ed., LSWA had an abortion at the age of fifteen and is now a licensed clinical social worker. She experienced negative psychological consequences for years following her abortion. She attempted suicide three times, abused drugs and alcohol, and suffered from low self-esteem. As a member of a psychiatric crisis team, Ms. Alekna has personally interviewed dozens of women who were suicidal or suffered from Post-Traumatic Stress Disorder after an abortion. Many of these women regretted not telling their parents about their abortions. "When the teens do talk to their parents," Ms. Alekna states, "they are often surprised to find out how supportive their parents actually are." She thinks that "parental notification is essential to helping pregnant teens make the best possible choice."

Ms. Felicia Bautista had an abortion at the age of fifteen without notifying her parents. After her abortion, she experienced adverse physical and psychological consequences

that lead her to spend one and a half years in counseling. "The abortion clinic made it seem like an abortion was nothing," Ms. Bautista says, "but living with it on a day-to-day basis, it was something." She wishes that her parents had been notified. "My parents would have supported me. They would not necessarily have taken the option of abortion away from me, but they would have explained my options . . . . I'm all for parents knowing."

Ms. Susanna Brennan had an abortion at the age of sixteen without notifying her parents. She regrets that her parents did not know that she was contemplating an abortion. In hindsight, she says, "Had my parents known . . . I'm sure they would have helped me through the pregnancy." Ms. Brennan experienced negative psychological consequences in the years following her abortion. Although she had no prior history of depression or substance abuse, she suffered from depression and eating disorders, entertained suicidal thoughts, and abused alcohol. Ms. Brennan strongly supports parental notification because "a child has no idea what she is undertaking when she has an abortion . . . . They are left alone making the most important decision of their lives."

Ms. Patricia Kelly Clark had an abortion at the age of seventeen. "I wouldn't have been so alone," she says, "if my parents had known the truth." At the time, she was not aware of the potential negative physical and psychological consequences of abortion. She states, "I needed that information and didn't get it." Since her abortion, Ms. Clark has suffered from miscarriages, infertility, and an anxiety condition that requires psychiatric treatment. She believes that parental notification is "essential for the well-being of any girl contemplating abortion."

Ms. Brenda Cochran's daughter, **Ms. Felicia Bautista,** had an abortion without her knowledge. She says, "I found out about my daughter's abortion in the most horrible way, because my child was dying." After her abortion, Felicia developed urinary tract infections that grew progressively worse until her kidneys were failing. She has also had many

ovarian cysts since her abortion. As a result, her doctor believes that her chances of ever having children are very slim. "If there had been a parental notification law," Ms. Cochran states, "I would have informed her that she might not have kids afterwards - I already knew about that risk. I would have said, 'Together as a family we can make it.' My being her mother for fifteen years was stripped away from me. She had to have permission even to go tanning, but not for an abortion . . . . Something needs to be done to protect these girls. I am all for parental notification."

Ms. Carole LaFreniere had two abortions as a minor without notifying her parents. She wishes that her parents had known she was contemplating abortion. She believes that, "If they had known, they would have helped me because they loved me . . . and I could have avoided a lot of misery and pain." After her first abortion, Ms. LaFreniere became depressed and started to abuse drugs. Following her second abortion, she twice attempted to commit suicide. Ms. LaFreniere supports parental notification because she believes "teenagers don't have enough life experience to make a decision that will change their lives. They need guidance and if they still have the abortion and have problems coping, their parents can get them help."

Ms. Eileen Roberts' minor daughter had an abortion without her knowledge. She wishes that she had known that her daughter was considering an abortion. After her abortion, Ms. Roberts' daughter became so severely depressed that she had to be hospitalized. While she was in the hospital doctors discovered that her abortion was incomplete and further surgery was required. She later developed pelvic inflammatory disease as a result of the abortion. Ms. Roberts says, "If I had been notified that she was considering an abortion I could have put my arms around her, told her that I loved her and that we'd work this out as a family."

Ms. Maura Jane Rogers became pregnant at the age of seventeen but decided not to have an abortion. Because of her mother's guidance and support she was able to carry her

baby girl to term and give her up for adoption. Ms. Rogers says that her mother stood by her: "She fought to get me into a school system that didn't want me and fought to get me proper health care when the hospital didn't want me."

Ms. Eve Sanchez Silver had an abortion at the age of sixteen without notifying her parents. She has also worked as the director of a center that assists women facing crisis pregnancies. Ms. Silver regrets that she did not tell her parents about her abortion. She indicates, "I did not have the benefit of their guidance concerning my decision to abort." She particularly wishes her parents had known so that they could have told her about her family medical history, which included early miscarriages, bleeding disorders, aneurysms and breast cancer. Since her abortion, Ms. Silver has had two episodes of breast cancer and eleven late-term miscarriages. In her work counseling pregnant women, she encountered young women who chose not to have abortions after they learned about their family medical histories from their parents. She also met young women who decided to give birth because of the positive support they received from their families.

Ms. Kim Macri became pregnant at the age of sixteen after being raped. She had an abortion without notifying her parents. She says that at the time "she didn't think she could go to her parents," but now she "regrets her abortion." In the years following her abortion, Ms. Macri experienced negative physical and psychological consequences. She abused alcohol, suffered from low self-esteem and had multiple miscarriages. When she finally became pregnant she says, "I thought that I didn't deserve to be a mother."